#

# Child Sexual Abuse

## Related guidance

* Child Sexual Exploitation
* Online Safety
* Underage Sexual Activity
* Harmful Sexualised Behaviour Practice Guidance & Procedure

## 1. Definition

Working Together to Safeguard Children defines sexual abuse as behaviour which:

“*Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening.*

*The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse.*

*Sexual abuse can take place online, and technology can be used to facilitate offline abuse.*

*Sexual abuse can take place within the family environment and outside of the home.*

*Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.*”

Sexual abuse often occurs in conjunction with the other categories of child abuse especially emotional abuse in order to maintain control and secrecy.

## 2. How do we Identify Child Sexual Abuse?

Healthy Developmental Sexual Activity encompasses those actions which are to be expected from children and young people as they move from infancy through to adulthood gaining an understanding of their physical emotional and behavioural relationships. Such sexual activity is characterized by mutual consent and understanding (see Harmful Sexualised Behaviour Practice Guidance & Procedure).

Child development incorporates physical, emotional, cognitive and sexual development. Children and young people develop sexually just as they do emotionally mentally cognitively and physically. The range of normative age-appropriate sexual behaviour changes as a child or young person grows and develops.

Most sexual behaviour displayed by children and young people will sit within a normative development range. The challenge for carers and professionals is to identify sexual behaviours that fall outside this range and then assist the young person to seek help for those problematic behaviours.

**See**: [A new typology of child sexual abuse offending](https://www.csacentre.org.uk/app/uploads/2023/10/New-typology-of-child-sexual-abuse-offending.pdf)

## 3. Risks and Indicators

Sexual abuse can be the most secretive and difficult type of abuse for children and young people to disclose. It may be particularly difficult to disclose abuse by a sibling.

Many children and young people do not recognise themselves as victims of sexual abuse - a child may not understand what is happening and may not even understand that it is wrong especially as the perpetrator will seek to reduce the risk of disclosure by threatening them, telling them they will not be believed or holding them responsible for their own abuse.

There may be a range of signs, but any one sign doesn't necessarily mean that a child is being sexually abused. However, the presence of several signs should indicate that you need to consider the potential for abuse and consult with others who know the child to see whether they also have concerns.

Please see: [Centre of expertise on child sexual abuse, Signs and indicators](https://www.csacentre.org.uk/research-resources/practice-resources/signs-and-indicators/).

Other factors to be considered:

1. Frequent house moves;
2. Isolation of children (and other members) within the family from practitioners, and the wider community;
3. Failure to register with a GP;
4. Frequent absences from school;
5. Historical adult disclosures of child sexual abuse within the family;
6. Failure to cooperate with agencies or to let police, children's social care or other agencies into the home, or letting children be seen alone by professionals;
7. Attempts to disguise injuries or attribute them to other causes;
8. A child or young person who self-harms, misuses drugs, alcohol or solvents, and/or develops mental health problems;
9. Domestic abuse within the family heightens the risk;
10. Repeated pregnancies with no evidence of a father;
11. Genetic abnormalities in pregnancy or in children who are born;
12. Practitioners may make assumptions about perpetrators. Women as well as men can be perpetrators, as can young people. There may be more than one perpetrator and children may remain at risk even after a known or suspected perpetrator is no longer in contact with them;
13. Perpetrators will also groom parents and other family members, or they may use controlling or violent behaviours;
14. Perpetrators may seek to control or manipulate the involvement of professionals with the child or young person;
15. Practitioners should be aware that the absence of positive findings of abuse as part of a medical assessment may not mean that the abuse has not occurred.

Practitioners should also consider potential sexual exploitation, please see Child Sexual Exploitation Guidance.

## 4. Protection and Action to be Taken

Whenever a child reports that they are suffering or have suffered significant harm through sexual abuse the initial response from all practitioners should be to listen carefully to what the child says and to observe the child's behaviour and circumstances. Practitioners must:

* Take what the child says seriously;
* Remain calm and avoid an emotional response;
* Avoid personal opinions and assumptions;
* Keep clear detailed and contemporaneous records of all concerns and disclosures;
* Clarify the concerns;
* Offer reassurance about how the child will be kept safe;
* Explain what action will be taken and within what timeframe.

The child must not be pressed for information, led or cross-examined or given false assurances of absolute confidentiality, as this could prejudice police investigations, especially in cases of sexual abuse.

When there are concerns around possible sexual abuse, whether or not a disclosure has been made, a referral to children's social care should be made. See the [Report a concern about a child process](https://www.nelincs.gov.uk/health-wellbeing-and-social-care/childrens-social-care/report-a-concern-about-a-child/).

Following a referral to children's social care a strategy discussion/meeting (see Strategy Meeting Guidance) will be arranged. Where a Strategy Discussion/Meeting takes place the core agencies involved with the child should participate it is particularly important in cases involving concerns about sexual abuse to include the Anlaby Suite (as per the Sexual Abuse Pathway). A clear plan should be agreed and circulated to each agency participant. Wherever possible these should be face-to-face meetings rather than telephone discussions to allow better analysis of the available information.

The strategy discussion/meeting will determine the next course of action, including:

* In all cases the need for a medical assessment;
* Arrangements for a visually recorded interview;
* Informing section 47 enquiries;
* Coordinating actions with any criminal investigation.

Strategy Discussions/Meetings must consider, in consultation with the Anlaby Suite for child protection the appropriateness and the timing of a paediatric assessment which in the case of sexual abuse will be through the Child Sexual Abuse Referral Centre (CSAAS). Further guidance is available on arranging a medical assessment, the issue of consent and the role of Even where prosecution is unlikely a medical assessment will be helpful to screen for infections, provide treatment, signpost counselling and support and for the therapeutic benefit of examination and reassurance. The Anlaby Suite should always be involved in strategy discussions in addition to the statutory health representative. This provided specialist advice and allows the child access to a pathway of support even if it is agreed a medical is not required. Any child protection medical assessment must be planned carefully in order to consider the welfare of the child and secure any forensic evidence. The CSAAS provides a range of support and information for children and young people and further details can be found on their website. Please see Sexual Abuse Pathway. [Multi agency pathway for suspected child abuse](https://www.nelincs.gov.uk/assets/uploads/2025/05/Multi-agency-Pathway-for-suspected-child-sexual-abuse-flowchart-May-2024.pdf)

**Any decision that there is insufficient evidence to take further police action does not mean that abuse has not occurred. Robust holistic multi-agency assessment is always required.**

Visually recorded interviews must be planned and conducted jointly by trained police officers and social workers in accordance with the [Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures](https://www.gov.uk/government/publications/achieving-best-evidence-in-criminal-proceedings). All events up to the time of the video interview must be fully recorded. Consideration of the use of visually recorded evidence should take into account situations where the child has been subject to abuse using recording equipment.

Visually recorded interviews serve two primary purposes:

* Evidence gathering for criminal proceedings;
* Examination in chief of a child witness;
* Relevant information from this process can also be used to inform Section 47 Enquiries, subsequent civil childcare proceedings or disciplinary proceedings against adults, where allegations have been made.

Practitioners should refer to the [NEL child sexual abuse briefing](https://www.safernel.co.uk/wp-content/uploads/2024/06/CSA-Briefing.pdf). Please also refer to the local [Child Sexual Abuse Strategy 2024-2027](https://www.safernel.co.uk/wp-content/uploads/2024/06/FINAL-DRAFT-CSA-Strategy-22.05.2024.pdf).

## 5. Issues

The single and most important consideration is the safety and well-being of the child or children.

In reconciling the difference between the standard of evidence required for child protection purposes and the standard required for criminal proceedings, emphasis must be given to the protection of the children as the prime consideration.

The investigation and enquiries must also address the religious, cultural, language, sexual orientation and gender needs of the child, together with any special needs of the child arising from illness or disability.

A victim support strategy and service should be established at the outset. Support will be required in pre-trial, trial and post-trial periods if the case/s proceed to court. Minimum periods for contact should be established. It is clear from experience in research about sexual abuse investigations that many victims and families feel strongly that it is important that they remain in contact with the same practitioners throughout the investigative process.

Where an Initial Child Protection Conference takes place great care should be taken beforehand if the child/young person wishes to participate. The child should not be put in the position of meeting the alleged perpetrator or of attending the meeting at the same time.

The Centre of Expertise on Child Sexual Abuse uses a model proposed by Finkelhor and Browne (1986) to describe four likely impacts of CSA:

1. Traumatic sexualisation (where sexuality, sexual feelings and attitudes may develop inappropriately);
2. A sense of betrayal (because of harm caused by someone the child vitally depended upon);
3. A sense of powerlessness (because the child's will be constantly contravened);
4. Stigmatisation (where shame or guilt may be reinforced and become part of the child's self-image).

In addition, the Centre highlights the impact that secrecy (including the fear and isolation this creates) and confusion (because the child is involved in behaviour that feels wrong but has been instigated by trusted adults) has on the child. While these impacts are not unique to Child Sexual Abuse in the Family Environment, their combination and intensity in the context that they take place makes the experience particularly damaging.

**Long Term**

In the long-term people who have been sexually abused are more likely to suffer with depression, anxiety, eating disorders and post-traumatic stress disorder (PTSD). They are also more likely to self-harm, become involved in criminal behaviour, misuse drugs and alcohol, and to commit suicide as young adults. It is important to ensure the information is shared appropriately with Primary Care Network, GP and universal services such as health visiting and school nursing so that this is recognised, and the young person is able to access the correct support throughout their life course.

**Disclosure**

Children may disclose sexual abuse directly and verbally while others may attempt to disclose by non-verbal means including changes in their behaviours, requiring those around them not just to focus on the behaviour but why the behaviour may be happening.

Whilst children and young people often disclose abuse while it is still ongoing, there may be a significant delay between the onset of the abuse and any disclosure. The younger the age of the child when the sexual abuse starts, the longer it usually takes to disclose.

Many children are experiencing multiple forms of abuse and may live in households that are not safe and in which emotional support is not available to them.

Disclosures are more likely to come in adolescence as they learn about healthy relationships and how to recognise abusive behaviour. Schools have a very important role to play in aiding the disclosure process in providing developmentally appropriate education and a safe space within which to disclose.

Children may disclose for a number of reasons possibly because they are not able to cope with the abuse any longer or because the abuse is getting worse. They may disclose in order to protect others from abuse or because they are seeking justice. Barriers to disclosure include [1]:

* Fear of not being believed, or of being told by the perpetrator that they would not be believed;
* Being scared, threatened with violence by the perpetrator or told by them not to tell anyone;
* Having no one to whom they felt able to disclose, which may be due to a lack of trust, a feeling of isolation, a lack of opportunity to speak to a social worker on their own, or not having the same social worker for a sustained period;
* Feeling embarrassed, ashamed or guilty, including because of grooming;
* Not understanding what was happening at the time or seeing the abuse as normal, possibly due to grooming or past abuse;
* Thinking that disclosure was not worthwhile, including due to a negative response to previous disclosure or because staff were involved or implicated in some way in the abuse;
* Fear of being separated from family;
* Inhibition by shock, trauma or mental health problems caused by the abuse;
* Fear that disclosure would affect their next placement.

Some groups of young people will have additional challenges in disclosing due to communication, religious, language, cultural or sexuality issues.

Disabled children are at increased risk of experiencing sexual abuse especially due to communication and developmental issues.

Whenever they choose to disclose, it is important that they are believed, that they are told what will happen next and kept informed and that they are provided with emotional support.

Research into young people's experience showed that they wanted someone to notice that something was wrong and to be asked direct questions.

Practitioners must be mindful of managing information to minimise the risks to the child when responding to any concerns or disclosures.

There will be situations where due to lack of forensic evidence or corroborating witnesses the threshold for criminal proceedings is not met. It is important in these cases that the lack of police action is not interpreted as disbelieving the child's disclosure.

## 6. Learning from Safeguarding Reviews and Points of Good Practice

Summary of risk factors and learning for improved practice around child sexual abuse (Source NSPCC 2020).

The reviews suggest that professionals are sometimes slow to identify sexual abuse as an explanation for a child's behaviour or medical presentations - particularly when other explanations are offered.

The learning highlights the importance of:

* Professionals' ability to recognise and respond to sexual abuse;
* Displaying professional curiosity and challenge with families, carers and other agencies;
* Keeping the child at the centre of practitioners' work.

This briefing focuses on child sexual abuse committed by adults [NSPCC Child Sexual Abuse: learning from case reviews](https://learning.nspcc.org.uk/media/1968/learning-from-case-reviews-child-sexual-abuse.pdf).

For information on harmful sexual behaviour (HSB) which is displayed by children and young people, read the [NSPCC HSB learning from case review briefing](https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/harmful-sexual-behaviour).

Points for good practice:

* 'Hearing the voice of the child' requires safe and trusting environments for children to be seen individually, speak freely, and be listened to;
* Practitioners must consider how to enable children to express their views while taking account of the child's age, development, and language. This will be compounded if the child is in any way threatened or coerced by an abusive parent, or if the child has other underlying developmental or communication needs;
* Previous research emphasises how children have extreme difficulty in expressing their concerns and that practitioners should not expect children to disclose abuse;
* The onus falls to the practitioners and requires an interest in how children express themselves through their behaviour and what they say rather than seeing them as 'difficult' or 'demanding';
* An active effort must be made to actually see and assess children in their families. This is a lesson 'so important that it must be re-emphasised and potentially relearnt as people, organisations and cultures change';
* Considerations must be made for children who do not communicate in English.

## 7. Resources

Sexual Abuse Pathway [Multi agency pathway for suspected child abuse](https://www.nelincs.gov.uk/assets/uploads/2025/05/Multi-agency-Pathway-for-suspected-child-sexual-abuse-flowchart-May-2024.pdf)

[Centre of Expertise on Child Sexual Abuse](https://www.csacentre.org.uk/)

[Independent Enquiry into Child Sexual Abuse](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1112123/the-report-independent-inquiry-into-child-sexual-abuse-october-2022.pdf)

[The Truth Project - Resource for professionals](https://www.iicsa.org.uk/victims-and-survivors/truth-project.html)

This link to a report from the Centre of Expertise on Child Sexual Abuse aims to help professionals involved in advising and referring children, young people and families, so that they better understand the role and purpose of a medical examination in situations where child sexual abuse (CSA) has been disclosed or is suspected. It presents evidence of the likelihood that medical examinations can:

* Obtain evidence of CSA (such as DNA or physical findings of CSA) or of other categories of abuse;
* Benefit health and wellbeing more broadly, such as by identifying sexually transmitted infections, blood-borne infections, the need for emergency contraception and other unmet physical and mental health needs.

[The Mouse Video](https://voicingcsa.uk/charity-film-awards-category-winner-2019/)

[NSPCC PANTS (The Underwear Rule)](https://www.nspcc.org.uk/keeping-children-safe/support-for-parents/pants-underwear-rule/)

[The Role and Scope of Medical Examinations when there are Concerns about Child Sexual Abuse: A Scoping Review (Centre of Expertise on Child Sexual Abuse)](https://www.csacentre.org.uk/documents/the-role-and-scope-of-medical-examinations-when-there-are-concerns-about-child-sexual-abuse-a-scoping-review/)

[Protecting Children from Harm (Children's Commissioner)](https://www.childrenscommissioner.gov.uk/publication/protecting-children-from-harm/) - A critical assessment of child sexual abuse in the family network in England and priorities for action.

['Making Noise: Children's Voices for Positive Change after Sexual Abuse'](https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/UniBed_MakingNoise-20_4_17-1.pdf) - Children's experiences of help-seeking and support after sexual abuse in the family environment.

[DfE Multi-Agency Response to Sexual Harassment & Abuse of Learners: emerging practice](https://trixcms.trixonline.co.uk/api/assets/nelincsscp/04fefc54-3183-4501-8f6a-efd1e00e7950/sexual-harassment-abuse-learners.pdf)

[Measuring the Scale and Changing Nature of Child Sexual Abuse and Child Sexual Exploitation - Scoping Report (July 2017), Professor Liz Kelly and Kairika Karsna (Centre of Expertise on Child Sexual Abuse).](https://www.csacentre.org.uk/app/uploads/2023/10/CSA-Scale-and-Nature-full-report-2018.pdf)

[Key messages from research on intra-familial child sexual abuse](https://www.csacentre.org.uk/research-resources/key-messages/intra-familial-csa/) (Centre of Expertise on Child Sexual Abuse).

[The Anlaby Suite](https://www.hey.nhs.uk/anlabysuite/)